2004 Special Needs Registry

Social Security Number ____-___-_____

Last Name _____First _____Middle Initial _____

Physical Address _____Key _____

Mailing Address (if different) _____City_____Zip _____

Do you plan to evacuate to a public shelter? ----------Y_____ N _____
Do you need Monroe County to transport you to a shelter? ---------- Y_____ N _____
(**If you answered *no* to both of the above, you will not be registered and need only to sign the back of the form. If you answered *yes* to either or both please continue to complete the form front and back.)**

If you do not have a phone, you must list a neighbor's phone number that we may use to contact you.
Nearest Mile Marker _____Home Phone#_____ Spanish only? Y ____N____
Sex M_____ F _____Date of Birth _____

If married: Name of Spouse _____Is Spouse registered? Y____N____

Residence type (**please check one**): Single family home/Duplex _____ Apartment _____ Boat _____
Condo _____ Campground/RV _____ Mobile Home _____ Other _____

Number of Pets in home: Dog _____ Cat _____ Other (type & #) _____
(**NOTE: Pets are not allowed in shelters, this information is for census only)**

Category storm you need transportation for 1 & 2 _____ 3 or higher _____ All _____
Are you a year round resident _____ or a seasonal resident _____Name months you are in county _____
Can you sit up and ride in a bus or van? ---------- Y _____ N _____
Do you need a wheelchair lift? ---------- Y _____N _____
Do you require an ambulance for transportation? ----------Y _____N _____
(*If yes, you will be contacted by Emergency Medical Services to assess your condition.*)
Are you receiving home health care?----------Y _____ N _____
If yes, name of agency-- _____

If you have a required caregiver, please list their name and phone number.
Name _____ Phone number _____
Total number of people that will accompany you to a shelter _____

You <u>must</u> give name & phone number of a neighbor or friend that we may use for an alternate contact: This person must live in your area & must be aware that they are listed as an alternate contact!
Name _____ Phone _____

******************************TO BE FILLED OUT BY REFERRING AGENCY *******************************
Agency Name: _____
Location & Phone Number: _____
New Client _____ Update Existing Client _____ Delete _____ (reason) _____

Please check all that apply:

About your condition:		Are you dependant on any of the following:	
No disabilities		*Oxygen*	
Blind / Hearing or Speech Impaired		*Respirator*	
Alzheimer's		Dialysis	
Epilepsy		Insulin	
On special diet		*I.V. Medication*	
Heart Condition		*Electricity*	
Full Paralysis		*Catheters*	
Back Injury		**About Your Mobility:**	
Severe arthritis		Walker / Cane / Crutches	
Terminal condition		Wheelchair	
Contagious disease (please specify)		Ambulatory(can get around on your own)	
High blood pressure		Ambulatory with assistance	
Pregnant, in 7th month or more		*Non-Ambulatory (bedridden)*	
Mental Illness (please specify)			
Is Shelter Assistance Needed For:			
Communications		Dressing changes	
Feeding		Medication	
Other disabilities:			

_____

_____

The information contained herein is true and correct to the best of my knowledge. I have read the information sheet attached and I understand the limitation on the services and level of care available. I understand that assistance will be provided only for the duration of the emergency and that alternative arrangements should be made in advance in the event I am not able to return to my home. I also understand that I will be responsible for any charges and costs associated with hospital or other medical facility care or medical transportation. I grant permission to medical providers and transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs. I also grant permission to emergency personnel to enter my home following an emergency if deemed necessary by proper authorities. I understand that this registration is voluntary and hereby request registration in the Special Needs Program. I understand that all information given will be held in strict confidence and will be used for emergencies only.

X_____ Date _____

Signature of Client Date of Signature

**********FOR OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE **********

Evac zone _____ EMS Zone _____ Date contacted _____

Transport to: Hospital _____ Nursing Home _____ Special Needs Shelter _____

HIPAA Forms Y____ N____ Transport by: EMS _____Social Service_____

Please return to the following: **Special Needs Registry**
Monroe County Transportation
1100 Simonton Street Room 1-180
Key West, FL 33040